Georgia Department of Community Health

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# GAMMIS Batch Dental Health Care Claim and Encounter Claim 837D Companion Guide 004010 X097A1

Georgia Medicaid Management Information System
Fiscal Agent Services Project

Version 1.6

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# Document Control

## Distribution List

| Name | Role | Representing |
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# Table of Contents




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# 1 Introduction

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid and all other health insurance payers in the United States comply with the EDI standards for health care as established by the Secretary of Health Services. The ANSI X12N implementation guides have been established as the standards of compliance for claim transactions.

The following information is intended to serve only as a companion guide to the HIPAA ANSI X12N implementation guides. The use of this guide is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This companion guide supplements, but does not contradict any requirements in the X12N implementation guide. Additional companion guides/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

Additional information on the Final Rule for Standards for Electronic Transactions can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. The HIPAA Implementation Guides can be accessed at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

## 1.1 Purpose

The 837 Dental transaction is used to submit health care claims and encounter data to a payer for payment. This transaction is the only acceptable format for electronic Dental claim submissions to the Georgia Department of Community Health (DCH). The intent is to expedite the goal of achieving a totally electronic data interchange environment for health care encounter/claims processing, payment, corrections, and reversals. This transaction will support the submission of Dental claims and Dental encounters.

The 837 Dental transaction is the electronic correspondent to the paper ADA claim forms; therefore, any claim types or encounter data submitted on the ADA forms correlate to the 837 Dental transaction, if data is submitted electronically.

All required segments within the 837 Dental transaction must always be sent by the submitter and received by the payer. Optional information will be sent when it is necessary for processing. Segments that are conditional are only sent when special criteria are met. Although required segments in the incoming transaction may not be used during claims processing, some of these data elements will be returned in other transactions such as the Unsolicited Claim Status (277 Transaction Set) and the Remittance Advice (835 Transaction Set).

HP and DCH have indicated at a “quick glance” items that have changed between the current fiscal agent and the new fiscal. Those items are highlight for easy identification.

## 1.2 Special Considerations for 837 Dental Transaction

1. **Subscriber, Insured = Member in the Georgia Medicaid Eligibility Verification System**

The Georgia Medicaid Eligibility Verification System does not allow for dependents to be enrolled under a primary subscriber, rather all enrollees/members are primary subscribers within each.


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**2. Provider Identification = Georgia Medicaid ID or NPI**

The implementation date for National Provider Identifier (NPI) was May 23, 2007.

Beginning May 23, 2008 for all health care providers, the Provider NPI, Provider Tax ID, Taxonomy Code and Zip Code + 4 postal code must be received in the appropriate loops. The NPI will be sent in the NM109, where NM108 equals XX, the Provider Tax ID will be sent in the REF02, where REF01=EI. The Taxonomy Code will be sent in the PRV03 and the Zip Code + 4 postal code will be sent in the N403 and N404.

For all non-healthcare providers where an NPI is not assigned, the claim must contain the Medicaid Provider Number within the appropriate loops within the REF segment where REF01 equals 1D.

**3. Logical File Structure:**

There can be only one interchange (ISE/IEA) per logical file. The interchange can contain multiple functional groups (GS/GE) however; the functional groups must be the same type.

**4. Submitter:**

Submissions by non-approved trading partners will be rejected.

**5. Acknowledgement Transaction (824 Application Reporting)**

A response transaction will be returned to the trading partner that is present within the ISA06 data element.

The Georgia Department of Community Health will provide an 824 Application Reporting Acknowledgment for all transactions that are received.

You will receive this acknowledgment within 48 hours unless there are unforeseen technical difficulties. If the transaction submitted was translated without errors for a request type transaction, i.e. 270 or 276, you will receive the appropriate response transaction generated from the request. If the transaction submitted was a claim transaction, i.e. 837, you will receive either the 835 or the unsolicited 277.

**Note:** The 835 and unsolicited 277 are only provided weekly.

**6. When NM108 = 24 or REF01=EI:**

If the NM108 equals 24 (Employer Identification Number (EIN)) or the REF01 equals EI (EIN) within any loop, the value in the corresponding NM109 or REF02 must be in the format of XX-XXXXXXX.

**Note:** This format includes the hyphen (-).

**7. Claims Allowed per Transaction (ST/SE envelope):**

The HIPAA implementation guide states on the CLM (Claim Information) segment that the developers recommend that trading partners limit the size of the transaction (ST/SE) envelope to a maximum of 5,000 CLM segments.


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The Georgia Department of Community Health does not have a maximum for the number of claims per transaction (ST/SE envelope), however the file size must not exceed 50mb.

**8. Document Level:**

The Georgia Department of Community Health processes files at the claim level. It is possible based on where the error(s) occur within the hierarchical structure that some claims may pass compliance and others will fail compliance. Those claims that pass compliance will be processed within the Medicaid Management Information System (MMIS). Those claims that fail compliance will be reported on the 824.

**9. Dependent Loop:**

The Georgia Department of Community Health, the subscriber is always the same as the patient (dependent). Claims containing data in the Patient Hierarchical Level (2000C loop) may not process correctly.

**10. Compliance Checking:**

Inbound 837 transactions are validated through Strategic National Implementation Process (SNIP) Level 4. In addition to Level 4, Level 7 patient (dependent) level will occur if 2000C patient loop is received. All other levels will be validated within the GAMMIS.

**11. Identification of TPL:**

For each claim at the header level, if loop 2320 (Other Subscriber Information) is present and SBR09 (Claim Filing Indicator) is not equal to MB (Medicare), 16 (HMO Medicare Risk), HM (HMO) or MC (Medicaid), the COB Payer Paid Amounts (AMT01=D) received in the 2320 loop(s) will be summed together for the Payer Paid Amount.

**Note:** The 2320 loop can repeat multiple times per claim


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# 2 Transmission and Data Retrieval Methods

HP Enterprise Services supports several types of data transport depending upon the provider's, trading partner's or billing agent's needs. Providers and their representatives submit and receive data using: Web Portal, Provider Electronic Solutions (PES) software, Remote Access Server (RAS), diskette/CD-ROM/tape, DVD, Secure File Transfer Protocol (SFTP) for batch transactions. Value Added Networks (VANs) are used for interactive transactions.

1. Web portal: Data is transmitted using the secure Web Portal. The Web Portal is normally available to customers 24 hours per day, seven days per week with the exception of scheduled maintenance. Submission options are Direct Data Entry (DDE) and Batch. The GAMMIS Web Portal (as a single gateway) is an important tool providing general and program specific information and links to other programs, applications, related agencies, and resources. The Web Portal has both secure (intranet) and non-secure (public internet) areas.

2. HP Enterprise Services provides free software called Provider Electronic Solutions (PES) for the submission of claim transactions. The system PC minimum requirements for PES are Windows 2000 or higher. This software complies with HIPAA requirements and is available to all providers who wish to submit claims electronically. The HIPAA-ready forms available for billing Georgia Medicaid using PES include:

    a. 837 Professional

    b. 837 Institutional (Inpatient, Outpatient and LTC)

    c. 837 Dental

    Georgia Medicaid providers can download a copy of the PES software from the Web Portal, have it sent using e-mail, or request a copy from the EDI Services to receive a CD through the United States Postal Service (USPS). A user manual, installation guide, and the initial password to access the PES application comes with the software. The EDI Services team will assist and answer any immediate questions or refer providers needing additional training to the Provider Relations team.

    **Note:** For additional information regarding specific PES procedures and functionality, please locate the PES Manuals located on our website at http://providerinfo.mmis.georgia.gov/providerprereadiness/home.aspx. Each transaction has its own PES manual on the website, for the following services: Professional Claims (CMS-1500) Billing, Dental, and Inpatient, Outpatient and LTC Institutional (UB-04) claims.

3. Remote Access Server (RAS): The RAS enables providers to access all options of the secure Web portal without the use of an Internet Service Provider. This option is available to users who do not have an existing Internet connection. The RAS server typically supports users that need a dial-up option. Trading partner data transmitted using the RAS can be transmitted the same as the Internet secure site using DDE or upload batch transactions.

    After the connection is established, the landing page is presented. A user either logs on and is presented with their secure provider page, or selects 'register' if they are a first-time user.


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Once logged on, the user will have access to the various secure Web portal options, including File Upload and File Download for EDI transactions.

4. Diskette/CD-Rom/DVD/Tape: Providers experiencing technical connection issues can mail a labeled copy of the EDI claims file downloaded on a CD-ROM, tape, or diskette. HP Enterprise Services does not anticipate that most providers will typically need to submit EDI transactions using diskette/CD-ROM/DVD/tape.

   Note: This option is reserved for special instances where the provider is having critical internet connection issues preventing them from accessing the Web Portal or server. The CD-ROM/diskette must be labeled to identify the trading partner and instructions on where to locate the EDI file for upload or it will be returned as unprocessed to the provider. Providers are responsible for correcting any connection issues to resume transmitting claims using the normal transmission methods (Web Portal, RAS, PES, or VANs).

5. Secure File Transfer Protocol (SFTP): SFTP uses Secure Shell (SSH) to encrypt and then securely transmit data across a potentially unsecured connection. Functionally SFTP (required) is similar to FTP, but offers protection to sensitive data. Secure Shell or SSH is a network protocol that allows data to be exchanged using a secure channel between two networked devices.

   This option allows provider, vendors, and all other trading partners to transfer claim files to HP Enterprise Services using the secure file transfer protocol server. Trading partners must notify HP EDI Service Team specifically if wishing to use this transmission method to transmit files.

   HP Enterprise Services requires that the SFTP submitters send their public key and HP Enterprise Services exchanges its public key with the submitter for encryption purposes. HP Enterprise Services will setup a username and password for the submitter to access the server.

6. Value Added Networks (VANs): VANs support interactive transactions for established vendors. VANs sign contracts with the State and set up unique VAN-specific communication arrangements with HP Enterprise Services.

Detailed information to assist with EDI related processes are available on the Provider Public Web site at: www.mmis.georiga.gov.

## 2.1 File/System Specifications

EDI will only accept Windows\PC\DOS formatted files.

EDI requires file extensions. Preferred extension is .dat, however other extensions such as .txt, .edi, .txn are allowed.

**Note:** Only one X12 transaction file is permitted in each "zipped" file. Any file size that is 5MB or larger is required to be zipped or compressed.

The Web portal is designed, but not limited to support the following Internet browsers:

1. Internet Explorer, version 6 or later; and

2. Firefox, version 1.5 or later


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# 3 Testing

In order to submit claims, a provider or their representative or billing agent must be authorized. The authorization process requires the submission of the Electronic Data Interchange Agreement, issuance of a trading partner ID, and testing to assure the trading partner can accurately submit transactions.

The trading partner certifies their transactions through EDIFECS Ramp Manager. The Ramp Manager product is a free self-service, Web-based testing tool for X12 transactions. It includes a number of support utilities for submitting, troubleshooting, and testing X12 files. The intent is to certify that an entity can successfully submit a compliant X12 file.

More information about testing procedures is located on the Provider Public Web site at: www.mmis.georgia.gov.


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# 4 Transmission Responses

For every transaction received, there is an expected response. The available responses are an Interchange Acknowledgement (TA1), a Application Reporting transaction (824), and an Unsolicited Claim Status (277U).

Once a transaction is received, it will go through a 'front end' compliance check called a TA1. The TA1 Acknowledgement is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structure. The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Once the transaction has passed the 'front end' compliance check it then goes through a syntax compliance edit. This edit is to verify the compliance within the ANSI X12 syntax according to the HIPAA Implementation Guides. The transaction will receive an Application Reporting Transaction (824) to provide feedback on the transaction. The 824 contains accepted or rejected information. If the transaction contains any syntactical errors, the segments and elements in which the error occurred will be reported in a rejected acknowledgement. If the transaction contains no syntactical errors, a positive 824 response will be generated and the transaction is passed on for processing.

Once the transaction is accepted the transaction is translated and processed. If the file contains an invalid Billing Provider, an X12 version 3070 – 277U will be generated.


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# 5 EDI Support

The HP Enterprise Services EDI Service Team is available to support trading partners and providers that exchange transactions electronically. Support functions include:

1. Enrollment processing for trading partners requesting to submit transactions electronically;
2. Installation assistance and submission support for Provider Electronic Solutions (PES) software;
3. Provide assistance to billing agents, clearinghouses and software vendors;
4. Identifying and troubleshooting technical issues; and
5. Data Exchange help.

The EDI staff will be available Monday through Friday 8:00 a.m. to 5:00 p.m. EST by calling 877-261-8785 or 770-325-9590.


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# 6 Control Segment Definitions for Georgia Medicaid 837 Dental Transaction

| X12N EDI Control Segments |
|---|
| ISA – Interchange Control Header Segment |
| IEA – Interchange Control Trailer Segment |
| GS – Functional Group Header Segment |
| GE – Functional Group Trailer Segment |
| ST – Transaction Set Header |
| SE – Transaction Set Trailer |
| TA1 – Interchange Acknowledgement |

## 6.1 ISA - Interchange Control Header Segment

Communications transport protocol interchange control header segment. This segment within the X12N implementation guide identifies the start of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file header record.

| 837 Dental Health Care Claim and Encounter Claims | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| B.3 | N/A | ISA | ISA01 - Authorization Information Qualifier | '00' – No Authorization Information Present |
| B.3 | N/A | ISA | ISA02 - Authorization Information | [space fill] |
| B.4 | N/A | ISA | ISA03 - Security Information Qualifier | '00' – No Security Information Present |
| B.4 | N/A | ISA | ISA04 - Security Information | [space fill] |
| B.4 | N/A | ISA | ISA05 - Interchange ID Qualifier | 'ZZ' – Mutually Defined |
| B.4 | N/A | ISA | ISA06 - Interchange Sender ID | 'Trading Partner ID' Supplied by Georgia Medicaid left justified and space filled. *The Trading Partner ID, will be the same Trading Partner ID used in current system.* |


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| 837 Dental Health Care Claim and Encounter Claims | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| B.4 | N/A | ISA | ISA07 - Interchange ID Qualifier | 'ZZ' – Mutually Defined |
| B.5 | N/A | ISA | ISA08 - Interchange Receiver ID | **'77034'** – GA MMIS Trading Partner ID.<br>Left justified and space filled.<br>Note: Current system this value was 100000. |
| B.5 | N/A | ISA | ISA09 - Interchange Date | The date format is YYMMDD. |
| B.5 | N/A | ISA | ISA10 - Interchange Time | The time format is HHMM |
| B.5 | N/A | ISA | ISA11 - Interchange Control Standards Identifier | 'U' – Interchange Control Standards Identifier |
| B.5 | N/A | ISA | ISA12 - Interchange Control Version Number | '00401' – Control Version Number |
| B.5 | N/A | ISA | ISA13 - Interchange Control Number | Interchange Unique Control Number – Must be identical to the interchange trailer IEA02 |
| B.6 | N/A | ISA | ISA14 - Acknowledgment Request | '0' – No Acknowledgement Requested<br>'1' – Acknowledgement Requested – HP Enterprise Services will return an 824 Application Reporting transaction. |
| B.6 | N/A | ISA | ISA15 - Usage Indicator | 'T' - Test Data<br>'P' - Production Data |
| B.6 | N/A | ISA | ISA16 - Component Element Separator | ':' – Component Element Separator |


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## 6.2 IEA - Interchange Control Trailer

Communications transport protocol interchange control trailer segment. This segment within the X12N implementation guide defines the end of an interchange of zero or more functional groups and interchange-related control segments. This segment may be thought of traditionally as the file trailer record.

| **837 Dental Health Care Claim and Encounter Claims** | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| B.7 | N/A | IEA | IEA01 - Number of included Functional Groups | Number of included Functional Groups |
| B.7 | N/A | IEA | IEA02 - Interchange Control Number | Must be identical to the value in ISA13 |

## 6.3 GS – Functional Group Header

Communications transport protocol functional group header segment. This segment within the X12N implementation guide indicates the beginning of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch header record.

| **837 Dental Health Care Claim and Encounter Claims** | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| B.8 | N/A | GS | GS01 - Functional ID Code | 'HC' – Health Care Claim (837) |
| B.8 | N/A | GS | GS02 - Application Sender's Code | This will be equal to the value in ISA06. |
| B.8 | N/A | GS | GS03 - Application Receiver's Code | This will be equal to the value in ISA08. |
| B.8 | N/A | GS | GS04 - Date | The date format is CCYYMMDD |
| B.8 | N/A | GS | GS05 - Time | The time format is HHMM |
| B.9 | N/A | GS | GS06 - Group Control Number | Group Control Number |
| B.9 | N/A | GS | GS07 - Responsible Agency Code | 'X' – Responsible Agency Code |


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| 837 Dental Health Care Claim and Encounter Claims | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| B.9 | N/A | GS | GS08 - Version/ Release/ Industry ID Code | '004010X097A1' – Version / Release / Industry Identifier Code |

## 6.4 GE – Functional Group Trailer

Communications transport protocol functional group trailer segment. This segment within the X12N implementation guide indicates the end of a functional group and provides control information concerning the batch of transactions. This segment may be thought of traditionally as the batch trailer record.

| 837 Dental Health Care Claim and Encounter Claims | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| B.10 | N/A | GE | GE01 – Number of Transaction Sets Included | Number of included Transaction Sets |
| B.10 | N/A | GE | GE02 – Group Control Number | Must be identical to the value in GS06 |

## 6.5 ST – Transaction Set Header

Communications transport protocol transaction set header segment. This segment within the X12N implementation guide indicates the start of the transaction set and assigns a control number to the transaction. This segment may be thought of traditionally as the claim header record.

| 837 Dental Health Care Claim and Encounter Claims | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| 53 | N/A | ST | ST01 – Transaction Set Identifier Code | '837' – Health Care Claim |
| 53 | N/A | ST | ST02 – Transaction Set Control Number | Transaction Control Number |


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## 6.6 SE – Transaction Set Trailer

Communications transport protocol transaction set trailer. This segment within the X12N implementation guide indicates the end of the transaction set and provides the count of transmitted segments (including the beginning (ST) and ending (SE) segments). This segment may be thought of traditionally as the claim trailer record.

| **837 Dental Health Care Claim and Encounter Claims** | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| 313 | N/A | SE | SE01 – Number of Included Segments | Total Number of Segments included in Transaction Set including ST and SE. |
| 313 | N/A | SE | SE02 – Transaction Set Control Number | Must be identical to the value in ST02 |

## 6.7 TA1 – Interchange Acknowledgement

The TA1 Acknowledgement is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structure. The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

| **837 Dental Health Care Claim and Encounter Claims** | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| B.11 | N/A | TA1 | TA101 - Interchange Control Number | Interchange control number of the original interchange received (ISA/IEA) |
| B.11 | N/A | TA1 | TA102 - Interchange Date | The date format is YYMMDD<br>Date within the original interchange received (ISA/IEA) |
| B.11 | N/A | TA1 | TA103 - Interchange Time | The time format is HHMM<br>Time within the original interchange received (ISA/IEA) |
| B.12 | N/A | TA1 | TA104 - Interchange Acknowledgement Code | 'A' – Transmitted interchange control structure header/trailer received without errors.<br>'E' – Transmitted interchange control structure header/trailer received and accepted, errors are noted. |


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| 837 Dental Health Care Claim and Encounter Claims | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| | | | | 'R' – Transmitted interchange control structure header/trailer rejected due to errors. |
| B.12 | N/A | TA1 | TA105 - Interchange Note Code | See 837D Implementation Guide for valid values. |

## 6.8 Valid Delimiters

The following delimiters must be used for the 837D for Georgia Medicaid otherwise the transaction may not process correctly.

| **Definition** | **ASCII** | **Decimal** | **Hexadecimal** |
|---|---|---|---|
| Segment Separator | ~ | 126 | 7E |
| Element Separator | * | 42 | 2A |
| Compound Element Separator | : | 58 | 3A |


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# 7 Companion Guide for the 837D Transaction

This section specifies X12 837D fields for which Georgia Medicaid has specific requirements.

| **837 Dental Health Care Claim and Encounter Claims** | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| **Header** | | | | |
| 55 | N/A | BHT | BHT02 - Transaction Set Purpose Code | '00' – Original |
| 56 | N/A | BHT | BHT06 - Transaction Type Code | 'CH' – Chargeable (Use with Dental Health Care Claim) |
| **Submitter Name** | | | | |
| 61 | 1000A | NM1 | NM109 - Identification Code | 'GEORGIA EDI Trading Partner ID' |
| **Receiver Name** | | | | |
| 67 | 1000B | NM1 | NM103 – Name Last or Organization Name | 'GEORGIA HEALTH PARTNERSHIP' |
| 67 | 1000B | NM1 | NM109 - Identification Code | '77034' - Georgia Medicaid Payer ID |
| **Billing Provider Name** | | | | |
| 71 | 2000A | PRV | PRV01 - Provider Code | 'BI' – Billing Provider |
| 72 | 2000A | PRV | PRV02 - Reference Identification Qualifier | 'ZZ' – Health Care Provider Taxonomy |
| 72 | 2000A | PRV | PRV03 - Provider Specialty Code | Provider Taxonomy Code |
| 78 | 2010AA | NM1 | NM108 - Identification Code Qualifier | 'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers<br>'24' – Employer's Identification Number<br>OR<br>'34' – Social Security Number for non-healthcare provider |


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| 837 Dental Health Care Claim and Encounter Claims | | | | |
|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| 78 | 2010AA | NM1 | NM109 - Identification Code | If NM108='XX' (NPI)<br>If NM108='24' (EIN)<br>If NM108='34' (SSN) |
| 82 | 2010AA | N4 | N403 - Zip Code | Billing Provider Zip Code + 4 postal code (excluding punctuation and blanks) |
| **2010AA Billing Provider REF Segment**<br>After May 23, 2008, REF01=1D, where REF02=Medicaid Provider Number should only be sent if the billing provider is not required to have a National Provider Identifier. | | | | |
| 84 | 2010AA | REF | REF01 - Reference Identification Qualifier | 'EI' – EIN or 'SY' – SSN<br>Healthcare providers must send NPI in the associated NM109 and the REF01='1D' should not be used. 'EI' or 'SY' must be used when NM108='XX'.<br>Non-healthcare providers must send this REF segment where REF01='1D'. NM108 must equal '24' or '34' when REF01='1D' |
| 84 | 2010AA | REF | REF02 - Reference Identification | If REF01='EI' (EIN)<br>If REF01='SY' (SSN)<br>If REF01='1D' (Georgia Medicaid Provider ID)<br>See comments on associated REF01 |
| **Subscriber Level**<br>For Georgia Medicaid, the insured and the patient are always the same person. Use this HL segment to identify the member and proceed to Loop 2300. Do not send the Patient Hierarchical Level (Loop 2000C). Claims received with the 2000C Loop may not process correctly. | | | | |
| 97 | 2000B | HL | HL04 - Hierarchical Child Code | '0' – No Subordinate HL Segment in this Hierarchical Structure |
| 99 | 2000B | SBR | SBR01 - Payer Responsibility Sequence Number Code | Refer to 837D Implementation Guide for Valid Values |


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| 837 Dental Health Care Claim and Encounter Claims | | | | |
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| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| 101 | 2000B | SBR | SBR09 - Claim Filing Indicator Code | 'MC' - Medicaid |
| **Subscriber Name** | | | | |
| 104 | 2010BA | NM1 | NM102 - Entity Type Qualifier | '1' – Person |
| 105 | 2010BA | NM1 | NM108 - Identification Code Qualifier | 'MI' – Member Identification Number |
| 106 | 2010BA | NM1 | NM109 - Identification Code | Georgia Member Medicaid Number |
| **Payer Name** | | | | |
| 118 | 2010BB | NM1 | NM103 - Name Last or Organization Name | 'GEORGIA HEALTH PARTNERSHIP' |
| 118 | 2010BB | NM1 | NM108 - Identification Code Qualifier | 'PI' – Payer Identification |
| 118 | 2010BB | NM1 | NM109 - Identification Code | '77034' - Georgia Medicaid Payer ID |
| **Claim Information** | | | | |
| 150 | 2300 | CLM | CLM01 - Claim Submitter's Identifier | Patient Control Number<br>Value received will be returned on the '835' Remittance Advice |
| 151-152 | 2300 | CLM | CLM05-1 – Facility Type Code | Enter the two-digit Place of Service (POS) code at the claim header.<br>*Note if the POS is not received at the detail, the header POS will be copied. |
| 151-152 | 2300 | CLM | CLM05-3 - Claim Frequency Type Code | Value indicates whether the current claim is an original claim, a void, or an adjustment.<br>Valid values are as follows:<br>1 = Original Claim<br>7 = Adjustment |


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| 837 Dental Health Care Claim and Encounter Claims | | | | |
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| | | | | (Replacement of Paid Claim)<br>8 = Void (Credit only).<br>The ICN to Credit should be placed in the REF02, where REF01='F8'.<br>Providers must use the most recently paid ICN when voiding or adjusting a claim. |
| 157 | 2300 | DTP | DTP01 – Date Time Qualifier | '435' – Admission |
| 157 | 2300 | DTP | DTP02 – Date Time Period Format Qualifier | 'D8' - CCYYMMDD |
| 157 | 2300 | DTP | DTP03 – Service Date | Admission date expressed as<br>CCYYMMDD<br>Required on inpatient visit claims. |
| 158 | 2300 | DTP | DTP01 – Date Time Qualifier | '096'– Discharge |
| 158 | 2300 | DTP | DTP02 – Date Time Period Format Qualifier | 'D8' - CCYYMMDD |
| 158 | 2300 | DTP | DTP03 – Service Date | Discharge date expressed as<br>CCYYMMDD |
| 162 | 2300 | DTP | DTP01 – Date Time Qualifier | '452 – Appliance Placement |
| 162 | 2300 | DTP | DTP02 – Date Time Period Format Qualifier | 'D8' - CCYYMMDD |
| 163 | 2300 | DTP | DTP03 – Service Date | Date of orthodontic appliance<br>placement expressed as<br>CCYYMMDD.<br>Required to report the date orthodontic appliances were placed. |


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| 164 | 2300 | DTP | DTP01 – Date Time Qualifier | '472' – Service<br>This DTP Segment is Required if all of the services on the claim was performed. (i.e. If 2300-CLM19='PB' is not present) |
| 164-165 | 2300 | DTP | DTP02 – Date Time Period Format Qualifier | 'D8' - CCYYMMDD<br>'RD8' - CCYYMMDD-CCYYMMDD (including dash) |
| 165 | 2300 | DTP | DTP03 – Service Date | Service Date |
| 180 | 2300 | REF | REF01 – Reference Identification Qualifier | 'F8' – Original Reference Number |
| 180 | 2300 | REF | REF02 - Reference Identification | Enter the 13-digit ICN or 17-digit TCN assigned to the original claim submission. (ICN/TCN to be credit/voided). |
| IG 182/ October 2002 Addenda 17 | 2300 | REF | REF01 - Reference Identification Qualifier | 'G1' – Prior Authorization Number<br>'9F' – Referral Number |
| IG 182/ October 2002 Addenda 17 | 2300 | REF | REF02 - Reference Identification | If, REF01=G1, REF02 =Prior Authorization Number<br>If, REF01=9F, REF02 = Referral Number |
| **Referring Provider Name** | | | | |
| 189 | 2310A | NM1 | NM108 - Identification Code Qualifier | 'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers<br>'24' – Employer's Identification Number<br>OR<br>'34' – Social Security |


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| 837 Dental Health Care Claim and Encounter Claims | | | | |
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| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| | | | | Number for non-healthcare provider |
| 189 | 2310A | NM1 | NM109 - Identification Code | If NM108='XX' (NPI)<br>If NM108='24' (EIN)<br>If NM108='34' (SSN) |
| 199 | 2310A | PRV | PRV03 - Provider Specialty Code | Referring Provider Taxonomy Code<br>(used for claims submitted with NPI) |
| 193-194 | 2310A | REF | REF01 - Reference Identification Qualifier | '1D' – Medicaid Provider Number<br>Beginning May 23, 2008 Healthcare providers were required to send NPI in the associated NM109 data element and the REF01=1D should not be used.<br>Non-healthcare providers must send this REF segment where REF01='1D' |
| 194 | 2310A | REF | REF02 - Reference Identification | If REF01='1D' (Georgia Medicaid Provider ID)<br>See comments on associated REF01 |
| **Rendering Provider Name** | | | | |
| 197 | 2310B | NM1 | NM108 - Identification Code Qualifier | 'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers<br>'24' – Employer's Identification Number<br>OR<br>'34' – Social Security Number for non-healthcare provider |
| 197 | 2310B | NM1 | NM109 - Identification Code | If NM108='XX' (NPI) |


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| 837 Dental Health Care Claim and Encounter Claims | | | | |
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| | | | | If NM108='24' (EIN)<br>If NM108='34' (SSN) |
| 199 | 2310B | PRV | PRV03 - Reference Identification | Rendering Provider Taxonomy Code<br>(used for claims submitted with NPI) |
| 201-202 | 2310B | REF | REF01 - Reference Identification Qualifier | '1D' – Medicaid Provider Number<br>Beginning May 23, 2008 Healthcare providers were required to send NPI in the associated NM109 data element and the REF01='1D' should not be used.<br>Non-healthcare providers must send this REF segment where REF01='1D' |
| 202 | 2310B | REF | REF02 - Reference Identification | If REF01='1D' (Georgia Medicaid Provider ID)<br>See comments on associated REF01. |
| **Other Subscriber Information** | | | | |
| 213-219 | 2320 | CAS | CAS02, CAS05, CAS08, CAS11, CAS14, CAS17 – Adjustment Reason Code | All external code source values from code source 139 are allowed. |
| 220 | 2320 | AMT | AMT01 - Amount Qualifier Code | 'D' – Payer Amount Paid |
| 220 | 2320 | AMT | AMT02 - Payer Paid Amount | Other Payer Amount Paid (TPL) |
| 222 | 2320 | AMT | AMT01 - Amount Qualifier Code | 'B6' – Payer Allowed Amount |
| 222 | 2320 | AMT | AMT02 - Payer Paid Amount | Other Payer Allowed Amount Paid (TPL) |


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| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| **Other Payer Name** | | | | |
| 241 | 2330B | NM1 | NM109 – Identification Code | This number must be identical to at least once occurrence of the 2430-SVD01 to identify the other payer. Georgia Medicaid captures third party payment amount(s) from the service line(s) in 2430-SVD02.<br>Note: The 2320/2330 Loop(s) can repeat up to 10 times for a single claim and the 2430 Loop can repeat up to 25 times for a single detail. |
| 246 | 2330B | DTP | DTP01 - Date Claim Paid | '573' - Other Payer Claim Adjudication Date |
| 246 | 2330B | DTP | DTP02 – Date Time Period Format Qualifier | 'D8' – Date Format (CCYYMMDD) |
| 246 | 2330B | DTP | DTP03 – Date Time Period | TPL Adjudication Date (CCYYMMDD) |
| **Line Counter** | | | | |
| 265 | 2400 | LX | LX01 – Line Counter | Georgia Medicaid will accept up to the HIPAA allowed 50 detail lines per claim. |
| 268-269 | 2400 | SV3 | SV304-1 - Oral Cavity Designation | Enter the appropriate Mouth Quadrant code for each procedure. Only the first value listed for each procedure will be used to process the claim.<br>Enter data in the Oral Cavity Designation Code or the Tooth Code/ Number and Tooth Surface, but not both. |
| 272 | 2400 | TOO | TOO02 - Industry Code | Enter the appropriate two- |


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| | | | | digit Tooth Number on the line item for each procedure. Each line should contain only one Tooth Number (for permanent teeth) or Tooth Character (for primary teeth). Refer to the National Standards Tooth Numbering System for the appropriate Tooth Number or Tooth Letter for the procedure.<br>Enter data in the Oral Cavity Designation Code or the Tooth Code/ Number and Tooth Surface, but not both. |
| 272 | 2400 | TOO | TOO03-1 - Tooth Surface Code | Enter the appropriate Tooth Surface code for each procedure.<br>Enter data in the Oral Cavity Designation Code or the Tooth Code/ Number and Tooth Surface, but not both. |
| 273 | 2400 | DTP | DTP01 – Date Time Qualifier | '472' – Service<br>This DTP Segment is Required if Dates of Service are different than those submitted within the 2300-DTP03, where DTP01=472. |
| 273 | 2400 | DTP | DTP02 – Date Time Period Format Qualifier | 'D8' - CCYYMMDD |
| 274 | 2400 | DTP | DTP03 – Service Date | Service Date |
| 275 | 2400 | DTP | DTP01 – Date Time Qualifier | '441' – Prior Placement. |
| 275 | 2400 | DTP | DTP02 – Date Time Period Format Qualifier | 'D8' - CCYYMMDD |


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| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| 276 | 2400 | DTP | DTP03 – Service Date | Prior Placement date expressed as CCYYMMDD.<br>If, the SV305 data element = "R - Replacement" the Prior<br>Placement date is required |
| **Detail Line Rendering Provider Name**<br>**Note:** Required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering provider information is different than the Billing/Pay-to Provider (2010AA\AB). | | | | |
| 291 | 2420A | NM1 | NM108 - Identification Code Qualifier | 'XX' – Health Care Financing Administration National Provider Identifier (NPI) for Healthcare Providers<br>'24' – Employer's Identification Number<br>OR<br>'34' – Social Security Number for non-healthcare provider |
| 291 | 2420A | NM1 | NM109 - Identification Code | If NM108='XX' (NPI)<br>If NM108='24' (EIN)<br>If NM108='34' (SSN) |
| 293 | 2420A | PRV | PRV03 - Reference Identification | Detail Level Rendering Provider Taxonomy Code<br>Used for claims submitted with NPI |
| 295-296 | 2420A | REF | REF01 - Reference Identification Qualifier | '1D' – Medicaid Provider Number<br>Beginning May 23, 2008 Healthcare providers were required to send NPI in the associated NM109 data element and the REF01='1D' should not be used.<br>Non-healthcare providers |


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|---|---|---|---|---|
| **Page** | **Loop** | **Segment** | **Data Element** | **Comments** |
| | | | | must send this REF segment where REF01='1D' |
| 296 | 2420A | REF | REF02 - Reference Identification | If REF01='1D' (Georgia Medicaid Provider ID)<br>See comments on associated REF01/ |
| **Line Adjudication Information** | | | | |
| 302 | 2430 | SVD | SVD01 – Identification Code | This number must match one occurrence of the 2330B-NM109 identifying Other Payer |
| 302 | 2430 | SVD | SVD02 – Service Line Paid Amount | Enter the Third Party Payment Amount (TPL) at the line item level only. |
| **Line Adjustment** | | | | |
| 305-311 | 2430 | CAS | CAS02, CAS05, CAS08, CAS11, CAS14, CAS17 – Adjustment Reason Code | All external code source values from code source 139 are allowed. |


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# 8 External Code Source List

Below is a list of external code source list links:

Place of Service (POS):

http://www.cms.hhs.gov/PlaceofServiceCodes/03_POSDatabase.asp#TopOfPage

**Adjustment Reason Codes (External Code Source 139):**

http://www.wpc-edi.com/content/view/695/1

**Patient Status Code**: Please refer to the Policy Manual located – www.xxx.com

**Note:** Additional external code sources references can be found in Section C of the 837D Implementation Guide.


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